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STATE OF MONTANA Department of Public Health and Human Services

SDMI PLAN OF CARE (CC5)

Admit Date:	Update:								
Level I Date:	Level II Date:								
Recipient Name (Last, First, Middle)	Address		Phone						
Medicaid Number (SSN)	Date of Birth Height Weight Sex				Sex	Marital Status			
Responsible Party:	Address Phone								
Significant Other:	Address		Phone						
Primary Health Care Professional			Address		Phone				
Primary Mental Health Professional			Address		Phone				
Counselor		Address		Phone					
Hospital Preference:		Residential () Lives () Lives () Live-i							
Medicare ()Yes □ No	surance								
Date of Referral to HCBS	Source	e Phone Number					Interview Date		
Allergies									
Diet: () General () Diabetic () Low Salt () Other (Specify)									
DATE MEDICAL DIAGNOSES IG			-9 CODE	DATE	M	IEDICAL DI.	AGNOSE	S	ICD-9 CODE
							-	SAGE	
DATE MEDICATIONS DO	SAGE	E FREQUENCY		DATE	MEDIC	MEDICATIONS			FREQUENCY
							+		
Comments									

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					-		D	ate		No
Mental Status/Psychological	osocial	Sta	itus							
Safety Measures/Fur	nctiona	l I i	mit	ations (Specify)						
Assistive Devices Us		. 21		ations (openly)						
Assistive Devices Of	sea									
Crisis Intervention P	lan Me	dic	al							
Crisis Intervention P	lan Psy	/cho	olog	gical						
FUNCTIONAL OVER	RVIEW		KE	Y: I = Independent N = Need	ds Assistance	D = Depe	nde	nt		
TASK	I	N	D	Comments	TASK	TASK		N	D	Comments
Bathing					Laundry	Laundry				
Dressing					Housekeepir	Housekeeping				
Exercise					Vision					
Grooming					Communication					
Toileting					Medication Mgmt					
Continence					Medical Mgmt					
Transfer					Money Mgmt					
Mobility					Behavior Mgmt					
Meal Preparation					Memory					
Diet					Time Mgmt					
Eating					Socialization					
Shopping					Other					
Escort					Other					
Transportation					Other					
OTHER TREATM	ENT/T	Н	ERA	APIES/SOCIAL SERVICES	AND INFORM	IAL SU	PPC	OR'	ΓS	YSTEMS
SERVICE		PROBLEM/NEE	PROBLEM/NEED		VID	ER		FREQUENCY		

SERVICE	PROBLEM/NEED	PROVIDER	FREQUENCY

DPHHS-AMDD-135 Recipient Name _ ____ Date _____ (Rev. 11/09) Page 4 PLAN ASSESSMENT SUMMARY PHYSICAL SUMMARY: Long term goals: Short-Term Objectives: PSYCHOSOCIAL SUMMARY: Long-Term Goals: **Short-Term Objectives:** Past Successes: DISCHARGE PLAN I have a free choice of all qualified providers of HCBS for each service included in my Plan of Care. \Box I understand there is a Plan of Care cost limit and a limit on the type of services available through the HCBS program. I have participated in the development of this Plan of Care and agree with it. \Box _____ Legal Representative: ___ Recipient: (Signature) (Signature) (Date) (Date) CMT Nurse: _____(Signature) Significant Other: ___ (Signature) (Date) ___ CMT Social Worker: _____ Health Care Professional:_

(Signature)

(Date)

(Date)

(Date)

(Signature)

(Signature)

Community Program Officer: _